PLEASE FILL OUT THE ADDITIONAL INFORMATION IF YOUR COMPLAINTS ARE DUE TO A VEHICLE ACCIDENT OR OTHER PERSONAL INJURY

PERSONAL INJURY (AUTO COLLISION/OTHER):

DATE OF ACCIDENT: _____/_____/_____ TIME: ____:____ am pm DID YOUR INJURIES OCCUR WHILE ON THE JOB? _____

WHERE ARE YOU HURTING AS A RESULT OF THIS INJURY? _____

_____

PLEASE DESCRIBE HOW THIS INJURY OCCURRED: _____

_____

HAVE ANY OF YOUR COMPLAINTS EXISTED IN THE PAST? _____ IF SO, PLEASE EXPLAIN _____

_____

MISSED ANY WORK DUE TO THESE INJURIES? (if so please list dates):_____ DATE LAST WORKED: _____

PLEASE LIST ANY ACTIVITIES THAT YOU ARE UNABLE TO PERFORM DUE TO YOUR INJURY: _____

_____

WAS A POLICE REPORT FILED? _____ NAME OF RESPONSIBLE PARTY _____

DO YOU HAVE AN ATTORNEY? (If so, please list name and phone) _____

ADDITIONAL INFORMATION FOR VEHICLE COLLISIONS:

PLEASE BE AWARE THAT THIS OFFICE BILLS 1ST PARTY CLAIMS ONLY – PLEASE SPEAK WITH THE RECEPTIONIST IF YOU DO NOT HAVE MED-PAY UNDER YOUR OWN VEHICLE POLICY OR OTHER GROUP HEALTH INSURANCE.

WHO WAS FOUND AT FAULT? PATIENT OTHER DRIVER

LOCATION OF ACCIDENT _____

WERE YOU: DRIVER PASSENGER PEDESTRIAN

HOW DID THE VEHICLES STRIKE ONE ANOTHER? _____

IF YOUR VEHICLE WAS MOVING, APPROX. HOW FAST WERE YOU GOING? _____ OTHER VEHICLE? _____

DID YOU RECEIVE EMERGENCY CARE AT THE SCENE? YES NO

POST-ACCIDENT HOSPITALIZATION? YES NO IF YES, LIST HOSPITAL AND DATE? _____

WERE YOU WEARING SEAT BELTS? YES NO EXPLAIN YOUR BODY'S POSITION AT IMPACT _____

DID YOUR VEHICLE HAVE AIRBAGS? YES NO DID THE AIRBAGS DEPLOY? YES NO

INSURANCE INFORMATION:

NAME OF *YOUR* INSURANCE COMPANY: _____ CLAIM #: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF ADJUSTER: _____ PHONE # _____ EXT _____

NAME OF *OTHER PARTY'S* INSURANCE COMPANY: _____ CLAIM #: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

NAME OF ADJUSTER: _____ PHONE # _____ EXT _____

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize my insurance carrier(s), trustees, executors, accountant, custodian, &/or attorney to make payment directly to The Healing Center for services rendered to me or my family by The Healing Center. I understand that all balances due are ultimately my responsibility and agree to pay any remaining balance in full. I authorize The Healing Center to prepare and release any medical information necessary to process this claim either to my insurance company or attorney. Furthermore, I authorize payment of medical benefits for any service rendered by The Healing Center be made directly to The Healing Center where assignment is accepted. This authorization serves as a Doctor's Lien, directing my attorney to withhold from any settlement, judgment, or verdict which may be paid to my attorney or me whatever sum is needed to protect The Healing Center, and to pay The Healing Center directly from those proceeds. I understand that any balance due on my account that is 90 days or more past due is subject to monthly interest. If The Healing Center has to resort to collection proceedings against me, I agree to pay all collection costs including the fees of collection agents, attorneys, and court costs, in addition to paying all fees due to The Healing Center for services rendered tome or my family. I also understand that if I suspend or terminate my care or treatment, any fees for products or professional services rendered will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE: _____

GUARDIAN'S SIGNATURE _____ DATE: _____